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time past.

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ISSUE THEME: *REIMBURSEMENT*

The official bulletin
for The Hampden District
of The Massachusetts
Medical Society.

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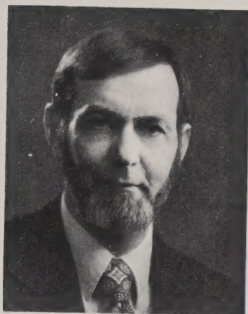
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Bruce B. Stoler, M.D.

Your President's Page

The February HDMS Meeting

Traditional medical ethics no longer occupies the same hallowed place as it did in the past. This subject is now changing as fast as antibiotic therapy recommendations changed in the '50s. At present it is under attack from many quarters simultaneously.

Because your medical society recognizes an obligation to help keep all physicians abreast of the present-day concepts of medical ethics, on February 15 the HDMS has invited all physicians and hospital administrators from the four western counties of Massachusetts (Region 1) to attend a Symposium to consider the changing ethics of medical practice today. Elsewhere in this issue you will find the announcement for this quarterly meeting of the membership.

We have been extremely fortunate to obtain as Symposium leaders the better part of the faculty of the *Kennedy Medical Ethics Program at Harvard*, including *Arthur J. Dyck, Ph.D.*, philosopher and ethicist, *Stanley J. Reiser, M.D., Ph.D.*, physician and author, and *William J. Curran, J.D.*, attorney and author of the familiar column "Medico-Legal Briefs" in the *New England Journal*.

The panel will deal not only with the challenges to traditional medical ethics imposed by recent court decisions in the areas of legalized abortion, care for the dying, informed consent and malpractice, but also with the very significant ethical implications of movements we physicians are all learning to live with: consumerism, peer review, state rationing of expensive medical care and equipment, "resuscitation committees", mandatory second-opinion programs, physician advertising and programs for recognition and rehabilitation of "impaired" physicians.



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I hope you will make a special effort to attend this mind-expanding symposium and to participate in the spirited audience discussion and questions which are sure to follow. Revised ethical guidelines dealing with these sticky problems will be suggested for your consideration. The program moderator will be *Dr. George Bronos*, chairman of our own Medico-Religious Committee.

As a member of HDMS, the cost of your dinner at the Marriott will be borne by the Society. However, you may host *one* guest at dinner—(a non-member physician?, your attorney?, religious advisor?, favorite nurse? or spouse?)—by sending an \$8 check with your reservation request to Mrs. Purdy by February 10.

— *Bruce B. Stoler, M.D.*
HDMS President

Hampden District Medical Society **DISTRICT MEETING**

Tuesday, February 15, 1977

Business Meeting 5:00 P.M.
Social Hour 6:00 P.M.
Dinner 7:00 P.M.

Marriott Baystate West Hotel
1500 Main Street
Springfield, Massachusetts

Dinner — Courtesy of HDMS

Program —

A Symposium on
"The Ethical Dilemmas in Medical Care Today"

Featuring members of the Kennedy Interfaculty
Medical Ethics Program at Harvard

William J. Curran, J.D.
Arthur J. Dyck, Ph.D.
Stanley J. Reiser, M.D., Ph.D.

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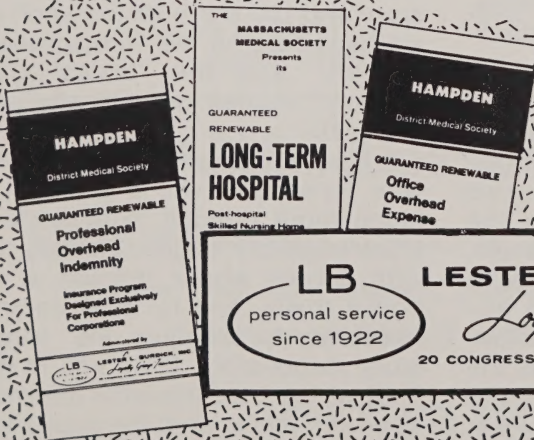
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Report of the Latest Media-Medical Meeting

At a meeting on December 1st with representatives of the press and electronic news media, hospital administrators, Foundation, PSRO and Western Mass. Health Planning Council, convened at the request of the medical society at the medical society headquarters, Dr. Stoler made the following opening statement, of interest to HDMS members:

"This meeting is in effect the continuation of the very successful media-medical program sponsored by the Valley Press Club. Not quite two months ago. At that meeting we heard many opinions: from the media, from doctors, from nurses, patients, health regulators, health care planners and hospital administration, and the principal message that came across was the need for all parties to have more complete information about what the others are doing and what still needs to be done.

In particular we heard from several sources that in dealing with such a significant subject to all of us as health and health care delivery, the press should treat the subject matter responsibly, fairly and in the light of the best available information. There is no place for the half-story and the scare tactics such as we have seen in the "unnecessary surgery" and the "breast xray dangers" stories both locally and nationally.

It is easy to take something off the wire service and use it "as is". It is much more difficult to evaluate it knowledgeably, to check a story out with people whose opinion a reporter trusts, and to write copy if necessary presenting the whole story responsibly, fairly and in the light of the best available information—but this is what the public has a right to demand. And I firmly believe that if the people have the

whole story they will draw the proper conclusions.

In this locality, as in many others, the generalist reporter dealing with health care matters is at the mercy of the special interest groups. He or she often doesn't know when a story comes off the national wires whether the condition described is true locally or not. He or she really doesn't know when called in to do a story about a new service being announced by a hospital P.R. man whether this service is being offered by other hospitals in the area already or not, or whether it really represents a significant advance or not.

Personally, I have heard reporters, hospital administrators and doctors agree that what is needed in this area are one or more experienced and knowledgeable medical news reporters who can cover the 'health care beat' the same way others now cover the 'city hall beat'.

Doctor Bloom and I have convened this meeting to discuss this felt need *with you* 'off the record' and to explore some of the ways that we can cooperate together to present medical news fairly, objectively and in the best interests of the public, who, after all, are your readers, your listeners, your viewers, and our patients."

— Bruce B. Stoler, M.D.
HDMS President

Notices to the Membership

If you would like your name to be considered by the Nominating Committee for a position in the administration to begin in June 1977, please call the HDMS office or give your name to Dr. Harry N. Memery-chairperson of the Nominating Committee.

If you would like to be considered for a committee position, please communicate with the HDMS Executive Secretary, Mrs. Vivian Purdy.

Your support or opposition to the HDMS Smoking Resolve is still solicited. No written comments have been received.

* * * * *

Mrs. Elsa Leahy has resigned as Advertising Director and her position will be temporarily filled by Mrs. Alicia Willard. All inquiries and material pertaining to advertising in the Hampden Hippocrat are to be directed to the Business Manager until a new advertising director is selected. The Editorial Board thanks Elsa for a brief period of assistance. Persons interested in the position should contact the Business Manager.

* * * * *

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Suggested HDMS Bylaw Change

re: "The Hampden Hippocrat"
Chapter VII Committees

Section 1. Executive Committee

(k) 1. Delete in its entirety and substitute: "A Committee on Publications to supervise all the publications of the Society and to be responsible for the publications and distribution of "The Hampden Hippocrat."

Section 4. Board of Editors (Delete a through f and insert)

(a) The Committee on Publications shall consist of five (5) members of the Society in good standing. Members of the Committee shall be appointed for terms of five (5) years, except that terms of office for the first committee established under this provision shall be for one (1), two (2), three (3), four (4), and five (5) years respectively. Vacancies occurring other than by expiration of a term shall be filled only for the unexpired portion of such term. The chairperson shall be designated each year by the Executive Committee with advice from the Committee on Publications.

(b) The Committee on Publications shall supervise all the publications of the Society and on behalf of the Society shall be responsible for the publication of and distribution of "The Hampden Hippocrat."

1. The Committee shall, from time to time or when instructed by the Executive Committee, cause various publications pertinent to the Society's interests to be printed and appropriately distributed. Such publications shall be subject to the approval and proper funding by the Executive Committee.

2. "The Hampden Hippocrat" shall be the official news organ of the Hampden District Medical Society as well as an instrument

through which the editorial staff, physicians and others concerned with health can express their opinions, observations, and recommendations for judgment by their peers.

(NEXT PAGE)

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All editorials and articles published must be properly identified as to authorship and considered to express only the views of the author, unless specifically identified as truly representing HDMS policy. "The Hampden Hippocrat" shall be issued no less than four times each calendar year under supervision of the Committee on Publications and in accordance with "Guiding Principles" as adopted by the Committee on Publications and approved by the Executive Committee.

3. The Committee on Publications may, with advice of qualified accountants and with approval of the Executive Committee, retain from funds derived from publications of the Society such reserve funds as may be necessary for the proper conduct of the financial affairs of the publications.

(c) The Committee on Publications shall meet no less than two (2) times a year to consider and act upon various pertinent matters with one such meeting being held no later than thirty (30) days before the end of each calendar year for expressly adopting a budget and appointing a Board of Editors and Business Manager for "The Hampden Hippocrat" for the coming calendar year; and the other, no less than thirty (30) days before the annual meeting of the Society, for expressly adopting an annual report for transmittal to the Executive Committee. Additional meetings may be scheduled by the Committee or convened by the chairperson upon the latter's own initiative or upon request by two (2) members of the Committee, the Editor-in-Chief of "The Hampden Hippocrat" or the Executive Committee.

For district membership consideration.

— Harry N. Memery, M.D.
Chairperson, By-Laws Committee



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Researchers at the University of Minnesota found that the average person absorbs only about half what he hears, even though he may be questioned immediately. Listening is a skill that must be developed.

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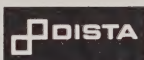
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Views of a Hospital Administrator

By

Harry C. F. Gifford

Every day in which one wakes up and follows his or her daily pursuits brings to mind the tremendous complexity of life. A simple shopping tour presents us with road traffic, parking problems, signs against shoplifting, credit cards and high prices. At work we find all sorts of different pressures eating at our time; mail to be read, papers to present, forms to be filled out, committees to meet and conversations to be held. Nothing seems to be accomplished easily.

Coupled with this complexity is the realization that we as individuals have all become so specialized, so urbanized that we no longer can truly do for ourselves completely. We must rely on others to carry out their function for our life to proceed. In order to maintain our high standard of living in a greatly mobile society we are totally dependent on each other. Even the lone artist is dependent on someone for the production of his canvas, his paints and his brushes.

Some of this complexity and interdependence has caused us to pause and question how to proceed and in what direction. Not all the products made by others for our use by the giant efficient industries have been good or useful. Not all the complex systems adopted have been cost effective or even economical. Not all the laws and the regulations written have organized society into complementary and supplementary parts. We, as individuals, are in danger of being swallowed up in the larger grouping. To combat this feeling the individual is looking for some degree of personal identity. Individuals call it consumerism. Cities and towns call it revenue sharing. The federal government calls it returning government to the people.

In health care the individual is beginning to question what he really wants. Some are trying to convince him he needs only primary care. Others are telling him he needs preventive care. A third group says he still needs acute and chronic illness treatment.



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In health care the consumer (who is really every person) feels that decisions on his wants and needs are too important and too personal to be left to those who provide care. Some even advise him that the professional's opinion is to be questioned as biased and self-serving.

But there's a difference in expressing one's wants and desires and providing those needs. For in this complex, interdependent society we must rely on others to answer our needs. We can't all govern so we elect representatives. We can't all manufacture things so we buy the products of others work. So with health care we can't all treat but we can make our wants and needs known.

By the same token in order to govern well the government must listen to the people. In order to provide quality health care the professional and the institutions must listen to the consumer. In order to provide personal and healthful care the professional must listen to the patient.

Therefore, when we simplistically divide the society for health care into providers and consumers we must pledge that there will be larger doses of listening as well as doing on the part of both. Should we not do this then the consumer will try to tell the provider how to provide and the latter will try to tell the consumer how to consume. Neither is in such a position to do so. It is the balance of both sides which will produce what we call high quality medicine and hospital care.

— Harry C. F. Gifford, President
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FEATURED ARTICLE:

Crying the Blues

by Grant V. Rodkey, M.D.

There is a current wave of vocal criticism of Blue Shield spearheaded by The Massachusetts Federation of Physicians, The Council of Medical Staffs, and, more recently, by The Hampden District Medical Society. The focus of objections is the Participating Physician's Agreement and the statutory prohibition of payment by Blue Shield for services rendered to subscribers by non-participating physicians. These factors restrain the escalation of physicians' charges in Massachusetts through the administration of the "Usual and Customary" program.

While there is a basic inequity in the contractual relationships between Blue Shield and its participating physicians, one must remember that this was written into the statute by our professional forebears when they designed legislation to create Blue Shield, and that we, ourselves, were not astute enough to have the legislation amended during years when that might have been feasible. In the present political climate, such a proposed change would be perceived by the public, the legislators, and the Governor as being inflationary to the cost of medical care and would have zero chance of favorable legislative action. Furthermore, recent federal court decisions in actions brought against Blue Shield plans in Ohio and California assure that no antitrust action against Blue Shield of Massachusetts would be successful, since the Corporation is engaged in the "business of insurance" for purposes of the McCarran-Ferguson Act, subject to regulation by the Commissioner of Insurance of the Commonwealth.

Recognizing these practical elements, during 1976 the Directors of Blue Shield voted to approve the institution of a "Cooperating Physician's Agreement" which would lessen the restrictions on a physician's charging practices provided due notification was given the subscriber in advance of the service. Unfortunately, this program requires the approval of the Commissioner of Insurance before taking effect, and the Commissioner has thus far refused this approval. Physicians through their societies and legislators have a legitimate interest in attempting to influence the Commissioner's decision on this issue.

Meanwhile, it is appropriate to consider just how badly the public and physicians are faring under the administration of Blue Shield's "Usual and Customary" program. Blue Shield subscribers represent 55% of Massachusetts residents of whom 80% have Master Medical coverage. In addition, approximately 13% of Massachusetts population is covered by Blue Shield as carrier for Medicare. The administration of these programs is among the most efficient in the nation as judged by cost and productivity. In terms of utilization review, Massachusetts Blue Shield has the most effective program in the United States, due in no small part to the direct involvement of its Board of Directors in the utilization review process and to an outstanding management team.

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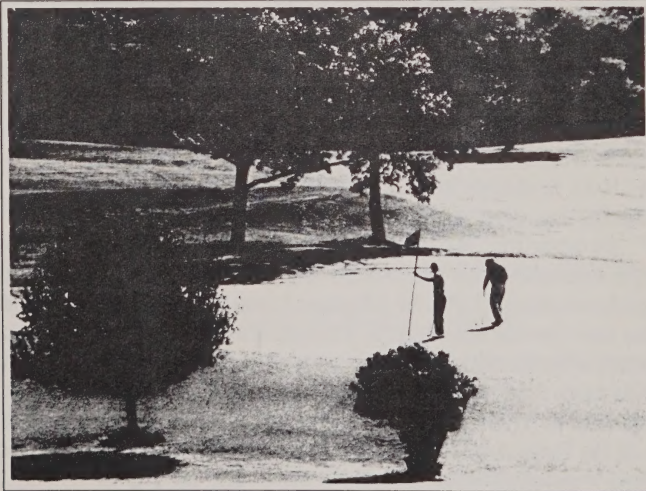
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Most physicians have been pleased by the increased recognition of charges to the 90th percentile, by elimination of area differentials in payment, and by decreased payment cycles from 33 to 18 days on average. Accuracy in claims processing has greatly improved and response to physician inquiry has become more effective and convenient. Physician charge profiles have been updated on a timely basis since the Corporation attained the ability to do so—a total of 8 times from January 1970 through July 1975, even though there was an enforced hold during 1973-1974 due to the Wage-Price Stabilization Program.

A startling fact is that total Blue Shield-Medicare payout to Massachusetts physicians increased from \$70 million in 1968 to \$170 million in 1975, while the number of participating physicians rose from 11,000 to 14,000. During the period July 1, 1975 to July 1, 1976, charges by physicians submitted to Blue Shield on the 25 most costly (unit price X utilization) procedures increased 34% in Massachusetts. Clearly, despite the special cost factors peculiar to physicians' practices, we are out of step with the rest of the economy.

This leads directly to a discussion of the "Usual and Customary" charge program which has been the focal point of physicians' criticism. There are some serious defects in this program, and one of these is reflected in the ability of the individual physician to set his own fee for a service. While this is good in many ways, it provides unfortunate rewards for the selfish or unscrupulous individual who hikes his fees in disregard of his public or professional responsibilities. Unfortunately, Massachusetts has some of these individuals who have raided the system and have invoked general public distrust of the entire profession; most of whom have been restrained

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and responsible in their charging practices; a fact confirmed by their having the highest rate of assigned Medicare claims in the nation. Another serious drawback to the program is the ability of a small, tightly-knit specialty group to rapidly escalate both individual charges and the "Customary" level, providing inappropriate high remuneration for their services when ranked against the large volume of total physicians' services. It is a surprising and disturbing fact that much of the outcry against Blue Shield originates from groups of individuals whom most physicians might consider to be too generously paid from the total pool of Blue Shield premiums. It is also a fact that Blue Shield premiums have reached such a high level that we are losing subscribers to competing health insurance carriers.

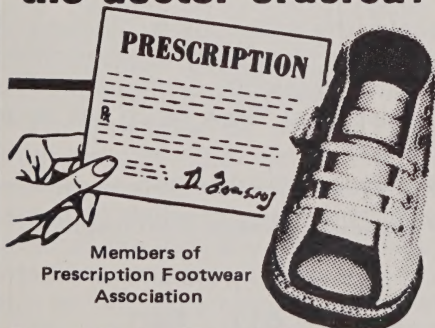
It is well known to Massachusetts physicians that the planned profile update in July 1976 has been deferred. Reasons for the delay are related chiefly to depleted financial reserves secondary to heavy payouts for physicians' services due to increased utilization and increased unit charges. Secondary factors include state-mandated mental health benefits, shift of hospital-based physicians to fee-for-service mode, and some enforced delay in premium increases due to resistance from the Commissioner of Insurance. It is noteworthy that the financial strictures of Blue Shield are not due to costly or inefficient management of the Corporation, and that increased premium charges have reached a level of diminishing returns in generating subscriber resistance.

In summary, although Blue Shield's relationships with its participating physicians are not always easy or comfortable, the Corporation and Massachusetts physicians have exercised their roles responsibly with primary focus on the public interest.

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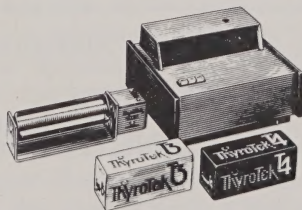
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FEATURED ARTICLE:

Indicators of Changes to Come Blue Shield's Concerns

by John Larken Thompson

Escalating health care costs during 1975 and 1976 have produced an environment in which all of the elements contributing to that rise have been placed under intense and continuing scrutiny. Physicians' fees have not escaped that phenomenon and it would be worthwhile to look at some of the early indicators which provide insight into possible changes in reimbursement mechanisms within the fee-for-service system. The strain upon the "usual and customary" system of payment became extremely pronounced in the private sector during the past year. Massachusetts Blue Shield was not untypical of Blue Shield Plans around the country when it deferred the updating of its profiles in July of 1976. At that time Blue Shield reserves stood at \$153,000 and rate increases in subscriber premiums were averaging 40% to 60% over the previous twelve months. The cost to Blue Shield in Massachusetts of updating profiles at that time was calculated to be in excess of 11% and it was apparent that sufficient funds were not available to meet the additional financial drain.

At the same time, increased criticism was being directed at the "usual and customary" program from at least three different sources. Many physicians argued that as a result of overall inflationary trends within the country the program was falling so far behind appropriate compensation levels that it should be replaced with a regional fee schedule.

Even more troublesome was the question raised by many physicians as to whether the "usual and customary" mechanism itself was fostering a significant change in the relative value or reimbursement relationship which was perceived to exist among the various surgical and medical procedures.

On the other hand, regulatory officials were increasingly critical of "usual and customary" because of its alleged inability to exercise constraint on fee escalation.

Finally, the public continues to be critical of the methodology because of an inability to understand the abstract statistical formula by which profiles and customary limits are determined which is frequently demonstrated in the response to a typical subscriber's question of "How much will Blue Shield pay my Doctor?"

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Similar problems have developed in regard to physicians' payments under the Medicare program and recent legislative enactments as well as those still pending make it clear that major changes are under way. The enactment of Public Law 92-603 in 1972 established the principle that the upper limit of Medicare payments would escalate no more than a rate described as an "economic index" which was to be annually established by the Social Security Administration. The application of that rate brought the anticipated result of retarding the upward movement of fees particularly at the "prevailing" fee level. The statistical result is that an increasing percentage of Medicare services are being paid for at the same prevailing fee level. At a recent meeting with officials from the Bureau of Health Insurance it was stated that 80% of the Medicare charges by physicians are paid at the prevailing fee level. Otherwise stated, the "reasonable and prevailing" system within Medicare has in fact become a moving fee schedule which will be updated on a periodic basis in accordance with a predetermined economic indicator.

This constraint on Medicare fees has brought about a further deterioration of the assignment rate which in turn has resulted in increased political pressure to modify those provisions of the Medicare law which permit physicians to decide on a case by case basis whether to accept assignment. This issue was most recently addressed in Senate No. 3205 filed by Senator Talmadge in the 1976 session of Congress. The Senator's approach to the sensitive issue of assignment was to attempt to establish an incentive which would make physicians more likely to accept assignment in each case. Desirable as the result might be, most observers criticize the proposed amendment from the standpoint that they would have little or no practical impact on how that decision was made by physicians.

Of far greater significance were the recommendations contained within the Forward Plan For Health, issued by Dr. Theodore Cooper, the Assistant Secretary for Health of HEW. That document sets forth a basic change to the current assignment provisions within the Medicare law by establishing a category of "full participating" physicians who would agree to accept assignment on all Medicare patients and in return be paid 100% of the "reasonable charges" leaving it to the Medicare carrier to bill the patient for any deductible or coinsurance. This mechanism would establish a substantial financial incentive to physicians to opt for the so-called "full participating" category since they would be spared the burden of collecting for any first party liability.

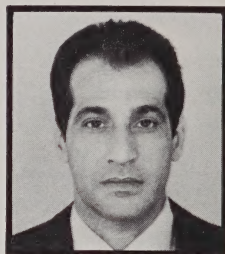
The Talmadge Bill and the recommendations contained in the Forward Plan indicate quite clearly that major changes within the reimbursement system of Medicare will occur within the near future. At the same time, Blue Shield in Massachusetts and the other Blue Shield and commercial carriers around the country will be examining the system to determine what modifications are necessary in order to meet the various criticisms arising out of the many constituencies which are affected by that system.

The usual and customary system has become the dominant payment mechanism in Massachusetts and throughout the country. It was never seen to be a perfect mechanism but during the past decade it has served both the physician and public reasonably well. However, it is apparent that it is now in the process of substantial change.

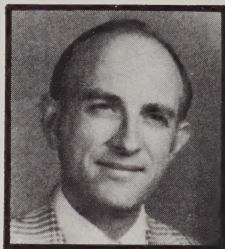
— John Larkin Thompson, President
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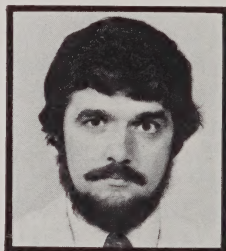
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H. Douglas Barnshaw, M.D. Baystate Medical Center-Spfld. Div. Springfield, Mass. 01107. Born: February 25, 1936. Medical School: Univ. of Pennsylvania-1961. Internship: Cooper Hospital-Camden, N.J. 1961-62. Residency: Univ. of Pennsylvania 1962-65. Specialty: Psychiatry.



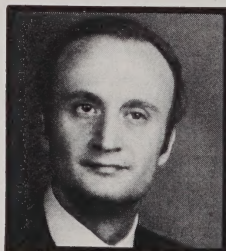
Paul C. Barton, M.D. 232 Mountainview Dr. Holyoke, Mass. 01040. Born: July 16, 1948. Medical School: Pennsylvania State Univ.-1974. Internship: Harrisburg Polyclinic Hospital (St. Joseph) 1974-75. Residency: The Milton Hershey Medical Cntr. Penn State-Radiology 1975-76. Specialty: Emergency Medicine.

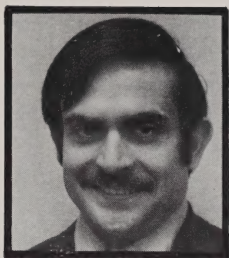


Roberta Berrien, M.D. Baystate Medical Center-Spfld. Div. Springfield, Mass. 01107. Born: September 28, 1944. Medical School: University of Tennessee-1974. Internship: Baystate Medical Center 1974-75. Residency: Baystate Medical Center 1975-Present. Specialty: Resident in Internal Medicine.



Claudio Borghesan, M.D. 780 Chestnut St. Springfield, Mass. 01107. Born: June 8, 1940. Medical School: University of Palermo, Italy-1964. Internship: N.Y. Medical College NYC 1970-71. Residency: French Polyclinic Hospital NYC 1973-74 (Gen Surgery), Metropolitan Hospital, NYC 1971-72 (OTO), Thomas Jefferson Hospital, Phila, Pa (OTO) 1974-76. Specialty: Otolaryngology.

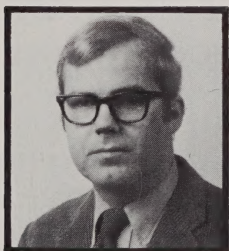




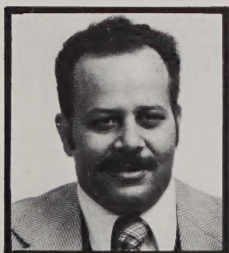
Robert H. Dann, M.D. 130 Maple St. Springfield, Mass. 01103. Born: December 11, 1937. Medical School: UCLA School of Medicine-1963. Internship: UCLA Center for Health Sciences (medicine) 1963-64. Residency: Internal Medicine-UCLA Center for Health Sciences, 1964-65. Radiology-Hospital of University of Penn. 1965-66 and 1968-70. Specialty: Radiology.



Joseph M. DiNardo, M.D. 39 Court St. Westfield, Mass. 01085. Born: March 5, 1926. Medical School: University of Geneva, Switzerland-1955. Internship: Allied Hospitals of Sisters of Charity, Buffalo, N.Y. 1955-56. Residency: Internal Medicine V.A. Hospital, Buffalo, N.Y. Aug. 56-Jan. 57, Internal Medicine St. Elizabeth Hospital, Boston 1967-69, Cardiology-University Hospital, Boston, 1969-70-Cardiology-St. Vincents Hospital, Worcester, Mass. 70-71. Specialty: Internal Medicine-Cardiology.

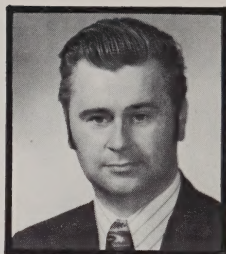


James F. X. Egan, M.D. 125 Liberty St. Springfield, Mass. 01103. Born: October 1, 1943. Medical School: Georgetown, Washington, D.C.-1970. Internship: Highland General Hospital-Oakland, California (rotating 6/70-6/71). Residency: Yale-New Haven Hospital, New Haven, Conn. OBS/GYN 7/73-7/76. Specialty: Ob-Gyn.

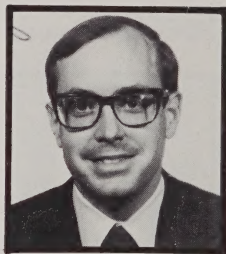


Nabil I. Fanous, M.D. 75 Van Deene Ave. West Springfield, Mass. 01089. Born: May 29, 1938. Medical School: Faculty of Medicine-Ein Shams University, Cairo, Egypt-1960. Internship: Bronx-Lebanon Hospital Center, N.Y. 7/1/68-6/31/69. Residency: Baystate Medical Center-Spfld, Mass. 7/1/69-6/31/73. Specialty: Surgery-Oncology.

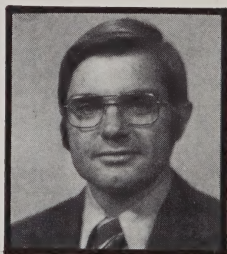
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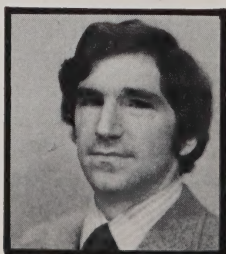
Robert G. Gray, M.D. 125 Liberty St. Springfield, Mass. 01103. Born: June 26, 1945. Medical School: Boston Univ. School of Medicine-1969. Internship: Jackson Memorial Hospital-Miami, Fla. 1969-70. Residency: Jackson Memorial Hospital, Miami, Fla. 1970-71, (1973-74 Internal Medicine); Fellowship (Rheumatology), Univ. of Miami School of Med., Miami, Fla. 1974-76. Specialty: Rheumatology.

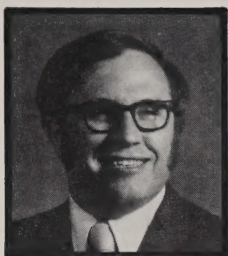


John R. Kirkwood, M.D. 780 Chestnut St. Springfield, Mass. 01107. Born: March 19, 1941. Medical School: Yale School of Medicine-1967. Internship: Children's Hospital Medical Center, Boston, Mass. Residency: Radiology-University of California, San Francisco Med. Cntr. 1967-68. Specialty: Radiology, Diagnostic.



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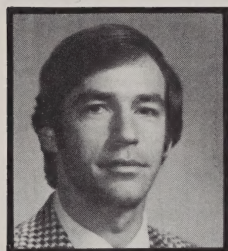




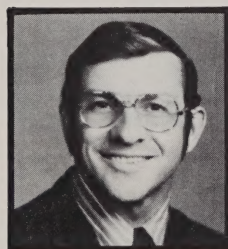
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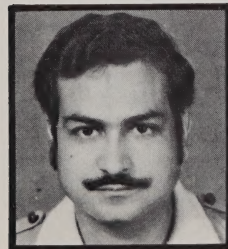
Loren J. Mednick, M.D. Dept. of Pathology-Holyoke Hospital. Holyoke, Mass. 01040. Born: November 5, 1932. Medical School: University of Basel, Switzerland-1967. Internship: New Britain General Hospital 1967-68. Residency: St. Francis Hospital, Hartford, Conn. Pathology 1968-1972. Specialty: Pathology.



Robert J. Olney, M.D. 130 Maple St. Springfield, Mass. 01103. Born: March 19, 1946. Medical School: State University of New York, Downstate Med. Cntr.-1972. Internship: Tufts Univ. Affiliated Hospitals-OB-GYN 1972-75. Residency: Same. Specialty: Obstetrics-Gynecology.



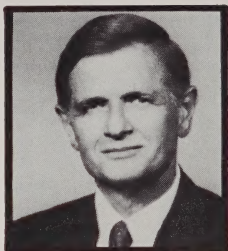
David W. Page, M.D. 780 Chestnut St. Springfield, Mass. 01107. Born: September 10, 1943. Medical School: University of Toronto-1970. Internship: Baystate Medical Center 1970-71. Residency: Baystate Medical Center 1971-75. Specialty: General Surgery.



Khalid M. Randhawa, M.D. 444 Montgomery St. Chicopee, Mass. 01013. Born: December 27, 1942. Medical School: Liaquat Medical College-1966. Internship: Liaquat Medical College Hospital, Pakistan 1966-67-Rotating at Catholic Medical Center, N.Y. 1968-69. Residency: Surgery-one year, Catholic Medical Center-three years of Otolaryngology. Specialty: ENT-OTO.

Charles R. Seiler, M.D. 100 Main St. Agawam, Mass. 01001. Born: October 22, 1946. Medical School: Jefferson Medical College, Phila., Pa.-1972. Internship: Baystate Medical Center 1972-1973-Rotating Medicine. Residency: Baystate Medical Center-Spfld. Div. 1973-1975-Internal Medicine. Specialty: Internal Medicine.

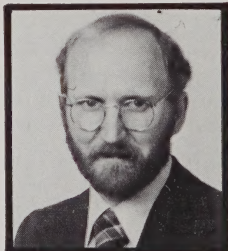
Allen Shepard, M.D. Dept. of Anesthesia. Holyoke Hospital. Holyoke, Mass. 01040. Born: November 8, 1920. Medical School: Hahnemann Medical College & Hospital of Phila., Pa.-1945. Internship: U.S. Naval Hospital, Newport, R.I., rotating-June 1945-May 1946. Postgraduate Clinical Pediatrics, New York Medical College, 8/2/48-9/2/48 & 8/1/49 to 8/31/49. Residency: Charity Hospital of Louisiana, New Orleans, Anesthesiology, July 1, 1960-62.



Mark M. Sherman, M.D. 125 Liberty St. Springfield, Mass. 01103. Born: August 3, 1940. Medical School: Cornell University-1966. Internship: The New York Hospital 1966-67. Residency: General Surgery-The New York Hospital-1967-68-1973-73-Thoracic & Cardiovascular-Boston University Med. Cntr. 1974-76. Specialty: Thoracic Surgery.



Michael R. Sorrell, M.D. 80 Congress St. Springfield, Mass. 01104. Born: August 4, 1945. Medical School: Albany Medical College-1971. Internship: D.C. General Hospital, Washington, D.C. 1971-72. Residency: Emory University School of Medicine 1973-76. Specialty: Neurology.



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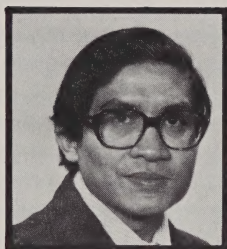
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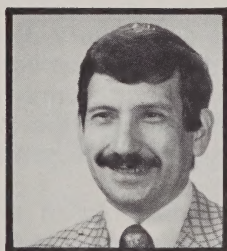
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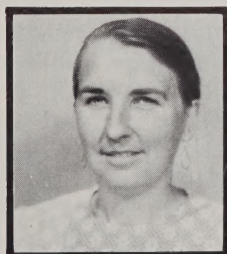
Phillip A. Stone, M.D. 57 Mulberry St. Springfield, Mass. 01105. Born: June 28, 1941. Medical School: Tufts Medical School-1968. Internship: Beth Israel Hospital, Boston, Mass. 1968-69-Surgery. Residency: Beth Israel Hospital, Boston, Mass. 1969-73-Surgery. Arizona Medical Center, Tucson, Arizona 1973-1975-Plastic Surgery. Specialty: Plastic Surgery.



Charuvuthi Upatham, M.D. Holyoke Hospital-Pathology Dept. Holyoke, Mass. 01040. Born: December 8, 1941. Medical School: Chulalongkorn University-1965. Internship: Thai Army Hospital, Bangkok, Thailand 1965-66. South Side Hospital, Pittsburgh, Pa. 1968-69. Residency: South Side Hospital, PGH, Pa., 1969-70 Altoona Hospital, Altoona, Pa. 1970-73. Specialty: Pathology, Nuclear Medicine.



Murray Watnick, M.D. Noble Hospital, Radiology Dept. Westfield, Mass. 01085. Born: April 10, 1935. Medical School: State University of New York, Downstate Medical Center-1960. Internship: Montefiore Hospital, New York, N.Y. 1960-61. Residency: Radiology, Boston City Hospital, Boston, Mass. 1966-69. Specialty: Diagnostic Radiology, Nuclear Medicine.



Nancy L. Weiss, M.D. 125 Liberty St. Springfield, Mass. 01103. Born: August 12, 1943. Medical School: Temple University-1969. Internship: Rochester General Hospital, Rochester, N.Y.-Rotating-7/1/69-6/30/70. Residency: Rochester General Hospital, Surgery-7/1/70-7/30-71-Saint Elizabeth Hospital of Boston-7/1/72-6/30/73. Baystate Medical Center-7/1/73-6/30/76. Specialty: General Surgery.

The Other Medicaid Fraud

by Walter F. Tauber, M.D.

Medicaid fraud, meaning criminal or unethical conduct by clients and physicians, dentists, drug stores, nursing homes ("providers") has received considerable national and local publicity. Equal time, for the other Medicaid fraud is long overdue: Fraud perpetrated by government on the people.

As part of the Great Society, Congress added Title XIX to the Social Security Act in 1965. With subsequent refinements **the poor** were to be offered the choice of obtaining personalized quality medical care from private physicians. No longer would indigent patients have to be faceless cases in impersonal assembly-line clinics. Massachusetts rapidly integrated its welfare system into this program, eventuating in a state take-over from the municipalities in 1969. Certain predictable effects were ignored at the time, either purposefully or by inadvertence. Welfare clients in large numbers saw that they could obtain recognition as individuals and sought out private physicians. With varying degrees of enthusiasm, physicians and dentists accepted personal responsibility for health care of these poor. Continuity of care replaced crisis intervention. Large reservoirs of pathology were uncovered and neglected illnesses were treated. State health budgets were projected statistically on middle class utilization of health services. It should have come as no

surprise (with a history of unmet needs), that such budgeting would be inadequate. Meanwhile the national economic upheaval, of simultaneous unemployment and inflation, had hit Massachusetts particularly hard. The opponents of social programs seized the opportunity to put pressure on officials to cut back on Welfare funds and Medicaid services. The governor and legislature found it politically necessary to concentrate budget-cutting efforts on Medicaid. Limits were put in place without regard to people's needs for medical services. Audits, cross-checks, centralization and computers were introduced, refined and proliferated to minimize abuse by clients and providers. Allegation of Medicaid fraud by clients and providers have increasingly attracted the attention of the criminal justice system in Massachusetts as well as elsewhere.

There is no doubt in anyone's mind that such abuses do exist and must be exorcized. The methods used to reduce fraud on the government, themselves constitute fraud by the government. Front page headlines shout out the number of questioned billings, while a small paragraph on an inside page acknowledges that most of these prove to be legitimate. Government agencies publicize the names of physicians with apparently high incomes from Medicaid. This is an obvious attempt to intimidate physi-

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cians who believe that *all* Americans are entitled to good medical care. The lists themselves are inaccurate. Do these doctors work long hours? Do they make themselves available to Medicaid patients, while others discriminate? What is the location of their offices? Are they rendering quality care? How do their incomes compare to those serving a larger percentage of "middle class" patients? The practitioners of trial and punishment by publicity are silent on the answers to these questions. No figures are offered to show the great savings offered to Medicaid by office care (at \$15 or less per visit) as opposed to Emergency Room utilization (starting at \$25 or more per visit).

The last general revision of Massachusetts Medicaid schedules to reflect inflation occurred in 1973. Of course, even at the time, the payments were well below those of other third parties and generally

prevailing fees. In 1975, the legislature enacted a 30% across the board *cut*. The effect of this cut was somewhat delayed by legal action taken by the Massachusetts Medical Society.

At one time dental care was eliminated. While fees have been reduced, the cost and uncertainty of collecting have markedly increased. Bills must be submitted within 90 days, but that is only the beginning. Too many bills get lost by the Department. Too many times clerical errors at the Medical Claims Control Center lead to rejections. Too many times bills are paid below the level that even the Department acknowledges as proper. Then tracers must be submitted on official forms provided for the purpose. These must be accompanied by copies of the original billing to prove that timely demands were made. It is not a rare event to have corrective re-billing rejected as duplicate

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invoices. It is a very frustrating experience to receive favorable reconsideration, followed by a rejection on the next print-out.

In theory, most fees for surgical procedures are standardized. Yet, it is a frequent experience to have "fees reduced by professional committee" without a request for explanation. Indeed, how could there be any explanation, when billing is only by code numbers? Inquiries on the subject invariably go unanswered. Although on paper, there is an appeals process available for disputed bills, requests for "fair hearings" are routinely ignored. Paper work does not become easier with the recurrent experience of publication of revised code numbers and other instructions *three to six months after they take effect*.

Obviously, as circumstances of individual clients change, their eligibility may change. Individual eligibility is determined by local welfare offices. "Temporary" cards or letters are issued, but the computers regularly refuse payment for services rendered before the computer is made aware of these clients.¹

I have focussed my attention to the difficulties of physicians in dealing with Medicaid. The suffering caused patients indirectly, by decreasing the willingness of all types of providers to serve them is not the only outrage they are subjected to. Arbitrary evaluations by local interviewers and various pressures put on clients, based on the personal prejudices of individual

social workers are by no means rare. Disability must be proved *before* the Welfare Department will accept certain adults on their rolls. No one explains how the diagnostic work-up for such determination is to be paid for by an indigent applicant. It would appear at all levels that the safe procedure for public employees is to decide against individual citizens whenever there is any doubt. In this way only the most persistent will be served in the way they should be. The civil servants take their cue from the highest administrative levels. According to a recent UPI story, the DPW would rather forego federal matching funds than obey the order of a judge to help needy people. A spokesman for the Department speaks of the impact of the order in fiscal terms. It would appear people do not count. Drug stores have been driven into bankruptcy by the long delays in payments. Other pharmacies have felt obliged to turn away Medicaid business in order to survive.

In the past few weeks, the Commonwealth may have designed the ultimate fraud. This fraud is officially known as the Old Bills Project. Briefly and simplistically stated, physicians were to resubmit previously unpaid bills for 1969 to June 1974. A week later new deadlines were issued for bills from July 1974 to June 1975 and from July 1975 to June 1976. The Department of Public Welfare says it will pay from "available funds" on a pro-rata basis. All bills not resubmitted are to be considered waived. Disallowances are to be final. Physicians are faced with the dilemma of having their claims wiped out, or to have

¹ A card certifying eligibility from 12/1/75 to 12/31/76 was rejected as not valid before 12/9/75(!).

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them settled at whatever discount the State may chose to pay.² Private bankrupts have gone to jail for less.

Until this latest outrage, I have tried to protect myself merely by pursuing each case to its end, but even the most easy-going optimist must now realize that we need to fight back. When I receive notice of the first part of the project, I urged the officers of the Massachusetts Medical Society to litigate the issues involved. I failed to convince them. Therefore, I had my attorney file suit in state court. When the second part of the project was thrust upon us, the Society filed in federal court, while I added the new facts to my complaint. Of course, I do not know whether I will prevail, but I am unwilling to submit meekly to official arrogance.

Litigation appears to be the only method for the crisis situation. Otherwise it is not our only—or even our best weapon. As a group, we must go to the press to present our side. Both as a group and as individual citizens we must, at all times, keep public officials aware of our grievances. The Massachusetts Dental Society was able to have dental services restored. A group of physicians, mostly pediatricians, refused to accede to Medical Society inaction and succeeded in limited restoration of payment cuts. Physicians must remember that they too are citizens with *the right to petition the government for redress of grievances*. Responsible citizens must not let rights atrophy through disuse.

— Walter F. Tauber, M.D.

Editor's Note: Perhaps the Commonwealth should grant the physician tax credits to offset State Income tax, as a means of paying its bill without funds or new taxes.

ANNOUNCEMENTS —

Two changes have occurred in the makeup of the Hampden Hippocrat's Editorial Board. 1) Dr. Setrag A. Zacarian has offered his resignation. It has been accepted with much regret; he was on the Board for eleven years. His succinct comments and ability to cut thru to the heart of an issue were and are appreciated. Our loss shall be the gain of the Journal of Dermatologic Surgery, to which "Set" has been appointed a Contributing Editor.

2) Dr. Lewis Whiting has volunteered to act as grammarian and punctuationist for the next few issues. An assist that the editor-in-chief will greatly appreciate, since these areas are his weaknesses (among others).

* * * * *



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Letter To the Editor

Dec. 27, 1976

It was with great interest that I read Dr. Stevens' Editorial in the December issue of the Hampden Hippocrat. This editorial touched upon most of the problems that are gnawing on the medical profession and are making the practice of medicine less and less rewarding both emotionally and financially. I do hope that this thoughtful and wide ranging article will bring forth serious discussion and hereby I hasten to add my bit. I will not waste time on the numerous points where I agree, instead let me point to those few instances where I think the direction or emphasis should be different.

Problem #1 Because I am convinced that NHI would become bankrupt in record time, I believe that reimbursement under it would become politicized and inadequate. Thus, to my mind to express a preference between NHI and NHS is like choosing between being robbed or enslaved. Both conditions ought to be combated by any and all means. Fortunately, it seems very unlikely that any administration will find the money to finance a national scheme except catastrophic insurance which is probably acceptable. To head off any further intrusion into the practice of medicine we should inform the public that the physicians share of the health dollar is small and the lion's share is received by the hospitals. We should become cost conscious in the tests,

treatments and hospitalizations we order. Since we order most of the things hospitals charge for, we must exercise oversight over hospital charges and protest, even in public if we find charges excessive.

Problem #2 While we may indeed need some physician administrators, I do not feel comfortable with the thought of adding another layer of bureaucrats to the ones already in being. And still, there is no substitute for being well informed. As a matter of self defense we will have to learn the language of the economist, the manager, the social scientist, for they are the ones that decide what the issues are as well as the options. Their jargon is the key to social mastery.

We must understand that we entered the age of "post-industrial" society and permanently slowed economic growth. In this era the distribution of income is removed from the market place and will be resolved through trade-offs among the strongest pressure groups. We must ask ourselves—how are we going to make ourselves strong enough?

Problem #3 Let us ask ourselves if there is any other group in society that is asked to accumulate "brownie points" to be allowed continued function to the benefit of society. Did the Army Engineers who pushed through the Teton Dam in Idaho go back to school? Did the politicians who got us into Vietnam



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get recertified? No! They are coming back to power saying that they learned from past mistakes. How about the men who designed the cargo door of the DC-10 or the ones that gave the world the "Starfighter" jets fondly called "the widowmaker" around the world. Should we allow ourselves to be singled out? Let's look at it another way if my most recent bout with CME is any indication, then in the next three years I will spend \$1500 for registration fees, \$3000 for hotels and travel and 8-9 weeks of my time. I will make this sacrifice to hear lectures that more often than not are indifferent and at times outright insulting to the men who dispense 90% of the medical care that is to be dispensed and do it remarkably well. To this skeptic CME seems to be the medical school's great opportunity to replace the fickle grants with steadier income. For my part I want none of it!

It is hard to argue with the analysis of problems 4, 5, 6, 7, 8, 9 and 10, so at last I have come to what I regard as an omission. May I suggest Problem #11: the divide between town and gown, between private practitioner and salaried physician? The salaried physician is one who either sees the bureaucracy as the wave of the future and is already making his niche in it, or, he is highly specialized and, not being able to wait for the referrals to come, sought refuge among the ranks of the salaried. His more advanced training engenders snobbery. He tends to isolate himself from the medical community, and becomes part of the palace guard of the administration. A word to these colleagues is in order.

All physicians who are salaried, owe a great deal of their standing to the private practitioners. It is the private practice of medicine that represents a viable alternative to full time employment. The number of physicians who exchange salaries for private practice each year keeps reminding the administration that they are competing for valuable skills. Should the private sector of medicine be seriously weakened the physician will indeed become a small cog in the machine operated by the administrator manager.

I submit that the encroachments of hospital administration and government upon our prerogatives do necessitate the creation of a new kind of organization that is more militantly on our side than anything we produced heretofore. This organization ought not be engaged in any activity other than looking after our own interests. Much like a labor union it should provide us with an effective way to deal with third parties, administrations and government. Needless to say that this organization need not be in conflict with the rest of organized medicine.

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I have initiated contact with the Mass. Federation of Physicians & Dentists that purports to be such an organization. The Federation expressed a desire to meet with interested physicians in the area and help us form a local chapter. Should you be interested in exploring this possibility, please contact me so that meeting with a Federation representative could be arranged.

References and suggested reading:

Books: Victor Fuchs: Who Shall Live?

Llwe E. Reinhard: Physician Productivity and the Demand for Medical Manpower

Daniel Bell: The Coming of the Post-Industrial Society

Journals: Journal of Medical Education

Hospital & Health Services Administration

— by Peter G. Sellei, M.D.

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Dates to Remember

MARK YOUR CALENDAR

Hampden District Medical Society Meetings

District Meetings

Tuesday, February 15, 1977

Tuesday, April 26, 1977

Executive Committee Meetings

January 18, 1977

February 15, 1977

March 15, 1977

April 19, 1977

May 17, 1977

June 14, 1977

Censor Meetings

Thursday, May 5, 1977

PRE-COUNCIL Meetings

Thursday, April 14, 1977

State Executive Committee Meetings

Wednesday, April 20, 1977

Wednesday, September 14, 1977

State Council Meetings

Wednesday, February 9, 1977

Wednesday, May 18, 1977

Wednesday, October 12, 1977

(to be held in Springfield)

State Annual Meeting

May 24, 25, 1977

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But in Washington's gimlet eyes, those qualities are diluted unless the AMA also has great numerical strength. And that's where you come in—you as individuals and as component societies.

Calling for unity against our common dangers is not a case of the boy crying "Wolf!" against make-believe wolves. The wolves are all too real. Consider some of them.

Regardless of a distaste for specifics, President-elect Carter has made it pretty clear that he will take an activist stance on health issues.

The sociologically oriented freshmen of the last Congress will be back in force, and without fear of Presidential vetoes.

You can expect moves for a heavily federalized, blow-by-blow form of National Health Insurance, with the Social Security Administration as its mismanager.

You can expect a drive for an even more repressive and arbitrary Health Planning Act (which comes up for renewal in 1977)—provided this act survives the joint lawsuit of the AMA and the State of North Carolina. The drive could include an amendment mandating all states to regulate health-care rates.

You can expect a move to expand Medicare-Medicaid benefits without

increasing the cost. How would this sleight of hand be achieved? By greater reliance on allied health professionals.

You can expect intensified efforts to federalize the standards for medical licensure and tilt the pharmaceutical wheel toward generic simulations.

How effectively can the AMA resist all the threats?

Well, ponder what it achieved in the last Congress. As the objective *National Journal* stated, the AMA

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got the fangs taken out of health-manpower legislation. It got the PSRO law amended to permit statewide PSROs and affirm the limitation of review to samples. It got the HMO Act amended, so that individual employees (including union members) can decide on their own whether to enroll in an HMO. It helped hold the line on NHI.

The AMA did all of this while forging ahead on many other programs—such as honing the skills of component societies in negotiating with third parties; expanding its program of continuing education; pressing its suit against the MAC rules; pressing for action against the Medicaid fraud that some politicians are using to smear our whole profession; establishing a firm (AMACO) to reinsure physician-controlled professional-liability programs.

The AMA's achievements have been your advantages. Its future and yours are one and inseparable. Your membership in the AMA is a paving block in your only sure road to a good tomorrow.

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A Message from the MMS President

The Loss of a Delegate

I personally find it hard to understand why an active member of the Society refuses to continue his membership in the American Medical Association.

There is only one national organization of physicians which can represent all of us, regardless of our specialty affiliations and special interests.

There is no alternative on the national scene. If we fragment nationally, the essential unity and power of the family of physicians is lost.

There is no organization with as great a potential to represent us nationally as the AMA. It can do anything a union can do, except order a strike.

The most commonly expressed reason why physicians will not continue membership in the AMA is: "It doesn't represent me."

The AMA represents the majority opinion of physicians in this country, as expressed by representative physicians who make up the AMA's House of Delegates. If members of the AMA do not like the majority opinion, then they must work at making their opinion the majority opinion. It is not as simple as that, of course, because it takes time to change men's minds. But it is done time and time again, and the AMA has made considerable changes in thought, attitude and decisions in the past five years.

I have been advised that unless we can get about 500 of our members to

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join the AMA before December 31, we will lose a delegate, reducing our representation from five to four.

The Society was very well represented at the first meeting of the American Medical Association in Philadelphia in May, 1847.

And since that time we have always had a voice in the proceedings. Our point of view has not always prevailed. I know of no delegate who resigned from the organization because we lost an argument.

As of this writing we have 3,577 members who also belong to the AMA. To retain our fifth delegate we need at least 4,001 of our members to be members of the AMA by December 31, 1977.

Dues are \$250/year. Drop us a line or give us a call if you do not have a bill form, and we will send it to you. In the Boston area call 536-8812. Outside the Boston area you can call direct on our toll-free WATS line: 1-800-952-7418.

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Book Review

by H. N. Simpson, M.D.

The Paintings And The Journal of Joseph Whiting Stock edited by Juliette Tomlinson (Wesleyan University Press, \$30.)

This volume, highly recommended by John Russell, art critic of The New York Times, contains all the extant papers, the journal and reproductions, many in color, of all the known surviving paintings of Joseph Whiting Stock.

This beautiful publication is of far more than passing interest both locally and medically. Miss Tomlinson, who is Director of the Connecticut Valley Historical Museum in Springfield, has carefully transcribed Stock's journal and has conducted an intensive search over a wide area and has discovered about a hundred of his paintings and miniatures.

Joseph Stock was born in Springfield January 30, 1815 and lived near the Armory where his father was employed. One day when Joseph was eleven he was playing with two other boys when a cart tipped over. The others escaped but Joseph received a crushing injury at the level of the first lumbar vertebra rendering him a paraplegic for the rest of his life. The remarkable thing was that he survived at all.

Strenuous efforts were made to stabilize the boy's fractures, but these were unsuccessful. The plaster cast was nearly three decades in the future. The young patient was immobilized on his back for months during which time decubitus ulcers developed accompanied by the inevitable infection, fever, cachexia

Ernest A. Byron, Jr.

• • •
SPRINGFIELD

and misery. Later he attributed his remarkable recovery to his parents and his attending physician, Dr. William Loring, a neighbor.

It was Dr. Loring who suggested to the bed-ridden boy that he try his hand at painting. After a few lessons the lad began copying portraits and then doing members of his family and friends. When Joseph was nineteen, by which time Dr. Loring was dead, the second physician entered the picture. He was Dr. James Swan, a graduate of Jefferson Medical School, who had been in practice elsewhere for several years before settling in Springfield.

Dr. Swan later described his findings when he first visited the invalid. "Although the circulation in the paralyzed parts was barely sufficient to exempt them from the laws of dead matter, yet there was no material for growth. Perhaps the bones had extended a little in length, yet the size of his lower extremities had not increased since the time he sustained the injury. His knees were bent at acute angles, though the joints were not wholly ankylosed. He had lain almost constantly in one position."

Dr. Swan determined to meet this therapeutic challenge and with the aid of two Armory mechanics built a wheel chair which stabilized the pelvis by using the thigh bones as levers and confined the feet in a foot stool by a cushion and belt over the knees. The body was supported by a belt attached to the chair and crossing the abdomen, while the sides and back of the chair were accommodated to the body by upholstery. An "ecology can" was supplied beneath the seat and an arrangement of handles at arm level attached by shafts and gears to the wheels allowed him to propel himself around the house. In another two years he was able to travel some distances by getting his chair into horse drawn vehicles and rail road cars, and was supporting himself

painting portraits.

Some years later disaster struck again. While Stock was heating varnish his clothing caught fire and he was seriously burned. The burns healed but lighted up a dormant osteomyelitis in his right hip. At this juncture the gravely worried Dr. Swan called in the town's leading surgeon, Dr. Joseph Flint, who incidentally was one of the founders of the Hampden District Medical Society.

The situation was desperate—a paraplegic with a high fever, a purulent infection involving the right hip, and a spontaneous dislocation of the head of the femur. Amputation at the joint was ruled out because of the poor circulation in the paralyzed limb, so Swan in describing Dr. Flint's operation stated simply, "A longitudinal incision was made above the trochanter, and the end of the bone elevated and sawed off."

Stock recovered and continued his painting career. He produced nearly a thousand portraits and miniatures before his death at the age of forty, of tuberculosis.

Joseph Stock's unstinting praise of his medical attendants, as recorded in his journal, who worked without anesthetics, antisepsis, antibiotics, blood transfusions, intravenouses or hospitals comes down to us after more than a century as a reminder that the art of medicine has not kept pace with its highly touted advances in science.

Miss Tomlinson's book is available at several local book stores or may be ordered directly from Wesleyan University Press, Middletown, Conn.

* * *

H.N.S.

MYLANTA
Frank Bobbin

Editorial Comments

This issue is the start of Volume XXXIII of the Hampden Hippocrat and its 35th year. Elsewhere in this issue, the reader is directed towards some proposed bylaw changes, which will, if approved by the HDMS membership, create a standing committee entitled—The Publications Committee. The Editorial Board of the Hampden Hippocrat and the Executive Committee of the HDMS are in favour of this development in the evolution of the Hampden Hippocrat. Hereby the autonomy of your “official bulletin” is better guaranteed yet through proper checks and balances the District Society is assured of an available publication for its many productions which need official printing or notification.

As always your comments, for or against, articles published in the Hippocrat are solicited. One of the stated purposes of the bulletin is to act as a sounding board. To the editor's regret, the sounding action seems to be inert or dead. The Board also solicits your ideas for future articles or features; it stands ready to “print what you would like to read”

Lead time is gradually being increased during this volume, so that by September's issue it will be 4 to 6 weeks. The new Deadlines are given below:

February 1977 issue #2	21 January 1977
March 1977 issue #3	18 February 1977
April 1977 issue #4	18 March 1977
May 1977 issue #5	15 April 1977
June/July 1977 issue #6	20 April 1977
September 1977 issue #7	5 August 1977
October 1977 issue #8	2 September 1977
November 1977 issue #9	30 September 1977
December 1977 issue #10	4 November 1977

Our able president Bruce Stoler, has five months left in his administration. He has accomplished much so far and he plans more for us. Again I would like to suggest that the membership consider that each administration last two years. With our current system of exposing a person to the examining light of the Society, by gradually allowing her or him to work up to the presidency, it would be difficult to have a candidate run for a second term. Effective leadership is possible in a 12 month term but it is difficult to have all that a president proposes completed in that time. The inertia of the system prevents all but the most direct and simple plans coming to fruition. A committee barely forms, accepts its charge and begins to follow through when its term expires. Unless the incoming president appoints or reappoints chairpersons with past experience, his new members have to take the time to learn their tasks, experience is lost. The routes of action and ways to get plans to develop should not have to be refound each 12 months.

— The Editor-in-chief

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